STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055760	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Healthcare & Wellness Centre, LP	415 South Garfield Alhambra, CA 91801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain a complete record for one (1) of two (2) sampled residents (Resident 1) as indicated in the facility's policy and procedure. This deficient practice had the potential for delayed or unnecessary treatment which could negatively affect the overall wellbeing of Resident 1. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included cardiovascular accident (CVA, commonly known as a stroke, a loss of blood flow to part of the brain, which damages brain tissue caused by blood clots and broken blood vessels in the brain), major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems), and dementia (a progressive state of decline in mental abilities) During a review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 10/28/2025, the MDS indicated Resident 1 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 needed partial/ moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) in toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand and chair/ bed-to-chair transfer and with walking for 10 feet.During a review of Resident 1's Order Summary Report (OSR) dated 10/20/2025, the OSR indicated Lorazepam 0.5 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount) give 1 tablet by mouth every six hours as needed for 14 days for anxiety disorder for manifested behavior episodes of easily gets anxious, start to tremble, and hands are shaky.During a review of Resident 1's informed consent (legal and ethical requirement that ensures residents understand and voluntarily agree to medical treatment after being fully informed of its risks, benefits, and alternatives) documentation for the use of Lorazepam (medication for anxiety [emotion characterized by feelings of tension, worried thoughts and physical changes]), dated 10/21/2025, the informed consent was not marked to indicate that the facility staff obtained informed consent from the resident or responsible party.During a concurrent interview and record review on 11/25/2025 at 1:10 PM with the Director of Nursing (DON), Resident 1's Nurses Progress Notes (NPN), dated 10/21/2025 was reviewed. The NPN did not indicate any information that licensed staff spoke to the resident or responsible party. The DON stated that there was no documentation that licensed staff obtained consent from the responsible party.During an interview on 11/25/2025 at 2:36 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated he spoke to Resident 1's responsible party. (family member [FM1]) to obtain consent over the phone. LVN 1 stated he did not and should have documented this conversation with FM1 on the progress notes and consent form. During a concurrent interview and record review on 11/25/2025 at 2:41PM with LVN 1, the informed consent documentation dated 10/21/2025 was reviewed. LVN 1 stated I forgot to write FM 1's name on the verification of informed consent form. LVN 1 stated the consent form was incomplete.During a concurrent interview and record review on 11/25/2025 at 4:14 PM with the DON, the informed consent (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 10/21/2025 was reviewed. The DON stated the licensed staff should have completed the informed consent after obtaining the consent with the resident's responsible party /family member over the phone. The DON added that the licensed staff should also have documented the discussion regarding the consent obtained from the resident's responsible party in the nurse's progress notes.During a concurrent interview and record review on 11/25/2025 at 4:18PM with the DON, the facility's policy and procedure (P&P) titled, Completion & Correction, revised 1/2012 was reviewed. The P&P indicated, entries will be complete, legible, descriptive and accurate. The DON stated if the licensed staff did not have complete and accurate documentation, the licensed staff did not follow the facility's policy.During a record review of the facility's P&P titled, Completion & Correction revised 1/2012, the P &P indicated to ensure that medical records are complete and accurate. The Facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation.